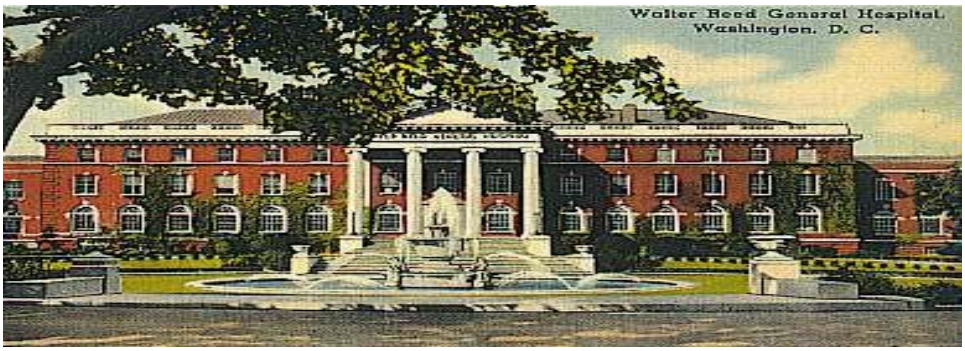
Walter Reed Cardiovascular Center



A Monthly Newsletter of the Cardiology Division of Walter Reed Army Medical Center

Commentary
Marina N. Vernalis, DO FACC

The Division of Cardiology at Walter Reed Army Medical Center remains committed to providing all beneficiaries the highest level of cardiovascular care.
We desire to continually ensure our access to care and hope this newsletter will help military providers learn about our capabilities.

In order to enhance this commitment we are initiating a referral base Continuing Medical Education (CME) series, outreach new patient clinics and a monthly newsletter. This newsletter will provide: 1) a review of a recent cardiovascular trial, 2) a synopsis of a current cardiovascular guideline, 3) ongoing investigational trials at Walter Reed and 4) referral numbers/pagers/E-Mail addresses.

Finally, with an up-to-date E-Mail list of primary care providers, we will provide more timely feedback on referrals.

Cardiovascular Update
Daniel E. Simpson, MD FACC

Recurrent stenosis following coronary artery stenting is the significant limiting factor for an optimal long-term outcome. The public is now aware of the results of recent stenting trials utilizing "coated" stents that have reduced restenosis.

This is exciting news but these drug-eluting stents (DES) are not yet available in the United States. Presently, the first DES from Cordis (Johnson & Johnson) is pending approval by the FDA.
DES have demonstrated a significant reduction in restenosis (in-stent neointimal proliferation or scar tissue build-up, usually occurring within 6 months of the procedure). However, there remains uncertainty over the actual cost of these devices. Utilizing them universally is unlikely because of the expense and limited data on many lesion subsets.

Several small registries and trials have demonstrated the efficacy of the DES. Two recently completed large trials confirm the reduction in restenosis.

SIRUIS
1058 patients with a de novo lesion were randomized to a sirolimus coated stent or a non-coated stent.

Restenosis was only 8.9% in the coated group versus 36.3% in non-coated.*

TAXUS II
537 patients with a de novo lesion were randomized to a paclitaxel slow release stent (131), a moderate release stent (136) or non-coated (270).

Restenosis was reduced from 25.5% to 5.5-9.3% (slow & moderate).*

* Presented at 2002 TCT

Guideline Review
Daniel E. Simpson, MD FACC

Class I – General agreement that procedure/treatment is useful & effective
Class II – Conflicting evidence and/or divergence of opinion
Class III – Not useful/effective and in some cases may be harmful

ECHO for MVP*

Class I
- Diagnosis; assessment of hemodynamic severity, leaflet morphology, and/or ventricular compensation in patients with physical signs of MVP.

Class II
- To exclude MVP in patients who have been diagnosed but without clinical evidence to support the diagnosis.
- To exclude MVP in patients with first-degree relatives with known myxomatous valve disease.
- Risk stratification in patients with physical signs of MVP or known MVP.

Class III
- Exclusion of MVP in patients with ill-defined symptoms in the absence of a constellation of clinical symptoms or physical findings suggestive of MVP or a positive family history.
- Routine repetition of echocardiography in patients with MPV with no or mild regurgitation and no changes in clinical signs or symptoms.

*ACC/AHA – Guidelines for Clinical Application of Echocardiography 1997
www.acc.org/clinical/statements.htm

Cardiovascular Trials at WRAMC

ARBITER II
Comparison of niacin versus placebo in patients with CAD with an LDL < 130 on a statin and HDL < 45.

Questions/Referrals
Please contact Lance Sullenberger

CARDIASTAR
PFO closure device versus standard anti-coagulation therapy with coumadin in patients with an embolic TIA/CVA and no other etiology.

Questions/Referrals
Please contact Daniel Simpson